Molina Healthcare of Washington, Inc.
Provider Change Form

Current Practice Information

Provider Name: _____ Contact Name: _____
Provider NPI: _____ Contact Email: _____
Group Name: _____ Requested Date of Change: _____
Tax ID: ☐☐-☐☐☐☐☐☐☐ Participation Status: ☐ Contracted ☐ Not Contracted

Requested Information to Update

Provide Complete Information. Your request will be processed for all participating programs unless noted otherwise in Section 7.

PLEASE PRINT OR TYPE

☐ Section 1. Provider Address/Phone Updates

☐ Add a Service Location ☐ Remove a Service Location ☐ Change Billing Address* ☐ Ph/Fax Change
☐ Correct Service Location

Current Address: _____
New Address: _____
Current Ph: _____ New Ph: _____ Current Fax: _____ New Fax: _____
Office Hours: _____

☐ Section 2. Tax ID Change*

If there is a change in name and/or ownership, please complete Sections 3 and 7.

Current Tax ID: ☐☐-☐☐☐☐☐☐☐ New Tax ID: ☐☐-☐☐☐☐☐☐☐

☐ Section 3. Change of Ownership/Name*

Please identify any and all other changes in Section 7.

☐ Requesting new agreement ☐ Converting from SSN to EIN ☐ Converting from EIN to SSN
☐ Requesting assignment of contract ☐ Other: _____

☐ Section 4. Panel Update

Panel Information is reported by location, please attach additional pages for multiple locations.

Service Location Address: _____
Age Limits: ☐ No ☐ Yes: _____ Gender Restrictions: ☐ No ☐ Yes: _____
Women's Health: ☐ No ☐ Yes Complete OB Care, including deliveries: ☐ No ☐ Yes
Provider Type: ☐ PCP ☐ Specialist Accepting New Members: ☐ Yes ☐ No
Publish in Provider Directory: ☐ Yes ☐ No

☐ Section 5. ☐ Add a Specialty ☐ Remove a Specialty ☐ Primary / ☐ Secondary *(indicate one)*

Specialty: _____ Taxonomy Code: _____

☐ Section 6. Additional Information/Comments

Please email this form and all supporting/supplemental information to:
MHWProviderInfo@MolinaHealthcare.com

* W-9 Form is required with submission.